Division of Disability and Elder Services DDE-2579 (Rev. 1-04)

POST SURVEY QUESTIONNAIRE

Completion of this form is voluntary. A copy of this questionnaire is available at http://www.dhfs.state.wi.us/forms/DDESNum.htm

Facility Name								Survey Date	
Facility Address Date Questionnaire Completed									
BQA Region ☐ Southern ☐ Southeast ☐ Nort	Western	Provider Type							
SECTION A. ON-SITE REVIEW PROCESS									
Use the following scale and check the number that applies.									
5 = Strongly Agree 4 = Agree 3 = Neutral 2 = Disagree 1 = Strongly Disagree NA = Not Applicable									
	5	4	3	2	1	NA	Comme	nt if 1 or 2 is checked.	
Survey process was clearly explained.									
2. Survey did not interfere with the delivery of patient / client / resident care.									
Survey assisted in your understanding of rules/regulations.									
 Survey Guide was easy to understand and helpful during survey. 									
Survey was completed in a reasonable amount of time.									
Survey time frames and plan of correction process were explained.									
Provider / facility staff comments on the survey were positive.									
Client / patient / resident reaction to the survey was positive.									
Communication with surveyor(s) was ongoing during survey.									
 Provider / facility had opportunity to discuss preliminary survey findings with the surveyor / supervisor. 									
11. Received knowledgeable response from BQA surveyor / supervisor if provider / facility requested clarification during survey process.									
12. The survey was conducted in a professional manner.									

Pag	je 2								
		5	4	3	2	1	NA	Comment if 1 or 2 is checked.	
13.	Surveyor(s) interacted respectfully with facility staff and clients.								
SECTION B. POST-SURVEY STATEMENT OF DEFICIENCY									
1.	Deficiencies clearly explained the basis for findings of noncompliance.								
2.	Deficiencies identified who, what, when, where and how, if applicable.								
3.	Deficiencies included specific actions, errors or lack of actions to explain findings of noncompliance.								
4.	Deficiencies were documented by accurate information.								
5.	Deficiencies clearly and concisely explained noncompliance with rules / regulations.								
6.	Documentation in deficiencies helped provider / supplier develop a plan of correction.								
7.	Changes in policies and/or procedures were made as a result of survey findings.								
	SECTION C. SURVEY TASKS EVALUATION Were the following survey tasks carried out in accordance with the Survey Guide? Check Yes, No or NA for each task.								
	SURVEY TASK	Ye	es	N	lo.	N	IA	COMMENT	
A.	Entrance conference								
B.	Sample selection]						
	Technical Assistance								
	Observation								
	Home visits]]		
	Orientation tour]						
	Assessment of applicable regulations]				
Н.	Environmental quality]				

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SURVEY TASK	Yes	No	NA	COMMENT			
I. Life Safety Codes	103	140	14/-	OOMMENT			
J. Clinical record reviews							
K. Staff interviews							
L. Patient/client/resident interviews							
M. Exit conference							
Additional comments or information about the onsite	survey pr	rocess		·			
Recommend one change that would improve the	e survey	/ eynerier	nce.				
Recommend one change that would improve the survey experience							
Type of on-site survey conducted (please identify all that apply)							
☐ Medicare / Medicaid Certification ☐ Health ☐ State Licensure / Certification ☐ Complaint Investigation ☐ LSC / Physical Environment ☐ Other							